South Dakota
HOSPITAL EXEMPTION
FROM PREADMISSION SCREENING NOTIFICATION

Instructions for the Hospital Discharge Staff: Use black ink and print clearly. FAX this notification to the nursing facility or swing bed and Adult Services & Aging Nurse Consultant for your Region prior to discharge from the hospital. This form must be completed fully in order for the Nursing Facility or Swing Bed to accept payment for nursing facility or swing bed services. Incomplete forms will be returned.

SECTION A: IDENTIFYING INFORMATION FOR APPLICANT/PATIENT

Last Name	First Name	MI

Living arrangement prior to the hospital admission:

[ ] group home [ ] psychiatric hospital [ ] own home/apt - alone
[ ] own home/apt – with friend or relative [ ] homeless [ ] prison
[ ] nursing facility [ ] other (please specify)

Street Address	City	State	Zip

SD County of Residence	Sex [ ] Male [ ] Female	Date of Birth (mm/dd/yyyy)

Social Security #	Medicaid Recipient [ ] yes [ ] no [ ] pending
Hospital Name	Hospital Phone #
Hospital Contact	Discharge from Psychiatric Unit to NF? [ ] yes [ ] no

SECTION B: DIAGNOSIS OF SERIOUS MENTAL ILLNESS, MENTAL RETARDATION OR RELATED CONDITION

1) If applicable, date of most recent Level II PASRR determination* _____ (mm/dd/yyyy) [ ] not applicable

* The date of the most recent Level II PASRR is only applicable for persons with diagnoses of serious mental illness, mental retardation or developmental disabilities as indicated in this section. Call Adult Services & Aging if unable to verify via local records.

2) Does the individual have a diagnosis of any of the mental illness as defined in the DSM-IV most recent version? [ ] yes [ ] no
If yes please list below.

[ ] schizophrenia
[ ] mood disorder
[ ] delusional (paranoid) disorder
[ ] panic or other severe anxiety disorder
[ ] somatoform disorder
[ ] personality disorder
[ ] other psychotic disorder
[ ] another mental disorder other than MR
If so, describe _____

3) Does the individual have a diagnosis of mental retardation(MR) (mild, moderate, severe or profound) as described in the ARSD 67:54:04:05. [ ] yes [ ] no

4) Does the individual have a severe, chronic disability that is attributable to a condition other than mental retardation, but is closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required for persons with MR?

[ ] yes [ ] no If yes, please specify;

SECTION C: CERTIFICATION FOR HOSPITAL EXEMPTION	
As the individual's physician, I certify that the individual *is discharged to a nursing facility or swing bed directly from a hospital after receiving acute patient care at the hospital; and *requires nursing facility services for the condition for which he/she received care in the hospital; and *as the physician, I certify, no later than the date of discharge, that the individual requires less than 30 days of nursing facility or swing bed services.	
Physician's Printed Name	
Physician's Signature	Date (mm/dd/yyyy)

Please note: The individual cannot be admitted to the nursing facility through the hospital exemption if all three criteria are not met. If the individual does not meet the three criteria for exemption, the individual may still seek nursing facility or swing bed admission through a pre-admission screen via completion of the "SCREENING FOR ADMISSIONS TO THE NURSING FACILITY OR SWING BED FOR MENTAL ILLNESS, MENTAL RETARDATION, DEVELOPMENTAL DISABILITIES" and referral to Adult Services & Aging if applicable.

SECTION D: IDENTIFYING INFORMATION FOR THE NURSING FACILITY OR SWING BED TO WHICH AN INDIVIDUAL WILL BE ADMITTED			
Facility Name		Facility Contact	
Street Address	City	State	Zip
Date of Expected Admission (mm/dd/yyyy)	Phone #	Fax #	

Printed Name of Hospital Staff completing this form	Time faxed to ASA
Signature of Hospital staff completing this form	Date (mm/dd/yyyy) faxed to ASA

Circle the name of the Adult Services & Aging (ASA) Nurse Consultant to whom you faxed this notification form.

Region I – Larra Miner
FAX 605-394-2363

Region II – Lana Glanzer
FAX 605-353-7103

Region III – Cassandra Varilek
FAX 605-882-5024

Region IV – Lori Baltzer
FAX 605-668-3014

Region V – Tricia Fjerestad
FAX 605-367-4272

THIS NOTIFICATION FORM MUST BE KEPT IN THE NURSING FACILITY OR SWING BED RESIDENT'S ACTIVE FILE. BY ACCEPTING ADMISSION, THE NURSING FACILITY OR SWING BED CONFIRMS THAT THE HOSPITAL EXEMPTION CRITERIA AND ALL APPLICABLE REQUIREMENTS OF SOUTH DAKOTA'S PASRR PROGRAM ARE MET. THE NURSING FACILITY OR SWING BED ACCEPTS THE ADMISSION ONLY AFTER RECEIPT AND REVIEW OF THIS NOTIFICATION FORM FOR 100% ACCURACY AND COMPLETION. THE NURSING FACILITY OR SWING BED ACCEPTS RESPONSIBILITY FOR REQUESTING A RESIDENT REVIEW (IF REQUIRED) FROM ADULT SERVICES & AGING PRIOR TO THE 30TH DAY FOLLOWING ADMISSION FROM THE HOSPITAL.